

HEALTH AND LIFESTYLE**Hunting for health, well-being, and quality of life**

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Health, well-being, quality of life, and lifestyle are central concepts within health science, although generally accepted definitions are still lacking. Lifestyle can either be seen as an independent variable and the cause of unhealthy behaviour or as a dependent variable, which is affected by conditions in the society. In the first case, the attention is directed on each individual case: maintaining or improving health requires changes in lifestyle and living habits. In this perspective, diet and physical activity are important features for health promotion. In the second case the attention is rather directed on structural conditions in society, for example the food industry, the lunches for children at school, and the “fast food” industry should be influenced to protect human health. The structural perspective has, so far, received restricted impact when it concerns prevention and promotion of health. Processes of individualisation in the society have to an increasing extent viewed health as an affair for the individual. The benefits of physical activity, healthy food and beverage, social support, and joy are documented scientifically. In general, the trend towards increasing responsibility for one’s lifestyle and health is positive, but might reinforce the inequality in health. With an even harder climate in society there might be a risk that individual health projects undermine the solidarity and the will to accept costs for medical treatment and care for people who risk their health through an unhealthy and risk-taking lifestyle. However, we argue that peoples’ well-being and quality of life presupposes a society that stands up for all people.

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Well-being, health, and quality of life are basic concepts in health science, caring science, and public health science. There are many different ways to describe the meaning of these concepts, however, generally accepted definitions are still lacking. Despite differing origins, well-being, health, and quality of life are most often used as synonymous concepts. For example, health has its origin in medicine whereas quality of life is a multidisciplinary concept. The meaning of the concepts varies over time and in different cultures. Well-being seems to have much in common with the modern concept of health. Sarvimäki (2006) means that well-being is the overriding concept and connects the other concepts. Nordenfeldt (1991) maintains that health is not an entirely necessary resource for good quality of life whereas subjectively experienced well-being is. In practice it is common that health and quality of life are comparable to well-being. This is also indicated in the most well-known definition of the concept of health that was formulated by the World

Health Organisation (World Health Organization, 1947) saying that health is a state of complete physical, psychological, and social well-being and not only the absence of disease or weakness. About 40 years later, WHO maintains that human health should be seen as a resource in everyday life rather than being regarded as an overriding aim for a person’s life. Health is affected by social and personal resources and is an invaluable asset in human life and social development. In the Jakarta document, World Health Organization (1997) points out that health is a human right, which contributes to that human beings can live socially and economically productive lives.

In a philosophical meaning, the concept of quality of life can be characterised by living “the good life,” whereas in social science quality of life is rather a part of the welfare concept. In psychology, the concept of quality of life is often used to describe a state of mental health and psychological well-being (Jahoda, 1958; Naess, 1987). However, quality of

life is difficult to operationalise and measure in an objective way. The mappings of Swedish people's level of living, which started during the 1960s, were content with describing people's material life conditions rather than reporting how these conditions were perceived by people themselves. In health research, the subjective dimension of health and ill health is considered as necessary. Individuals' objective health status is established by the medical expertise whereas their subjective health is established through their personal experiences. Accordingly, objective and subjective health are separated in health research. The objective health can be stated as satisfying by medical doctors although the individual subjectively reports illness. The contrary, subjectively good health can occur simultaneously as medical examinations indicate signs of disease. In health research, certain instruments have been developed to measure and quantify people's subjectively reported quality of life. As a common conception of the definition of quality of life is still lacking, these measurements are based on different definitions. This is a condition that makes comparisons between investigations difficult or impossible. Of course, it is important to be aware of these limiting facts and avoid comparing "apples with pears."

Biomedical versus holistic view of health

The differences between definitions of health can be understood as caused by differences in ontological assumptions about the nature of reality and by the view of the nature of human beings (Tengland, 2007). The biomedical view of reality—and of health—is built on the positivistic ideal of science, which prioritises what our senses can notice and what we objectively can measure. Thereby, reality—as well as health—appears as unambiguous and independent of the observer. The view of health has successively changed and expanded due to the progress of behavioural sciences as well as by changing patterns of diseases in the western world. Thereby the biomedical view of health has changed into a more holistic way to look at health in human beings. This means that peoples' experiences, thoughts, feelings, emotions, as well as other phenomena that cannot be measured are included in the concept of health. The body and the soul are regarded as closely related and health is viewed as a multi-faceted perfectible resource. One can say that human beings have full health only if they have the ability to realise all their vital goals. If they are lacking necessary conditions for reaching at least minimal satisfaction within important areas of life, ill health is present. Such an expanded view of health seems to be necessary in understanding the pattern

of diseases in the modern society. It is obvious that the increasing wealth in society contributes to the development of new types of chronic diseases, so called diseases of wealth. Social and behavioural sciences relate these diseases to peoples' ways of living and their choices of lifestyles. These diseases are therefore called lifestyle diseases.

Lifestyle and health

Research indicates that many people have opinions on what constitutes a healthy lifestyle. This includes having friends, eating a healthy diet, having enough sleep, exercising regularly, avoiding or learning to manage stress, going for health checks, avoiding tobacco and excess alcohol consumption, and other behaviour-involving risks such as driving under the influence of alcohol. This knowledge, however, does not always seem to steer their behaviour. One explanation might be that it is not always based on completely rational motives. This also applies to decisions and actions that shape our lifestyle. For many people a personal lifestyle is not just about health, but also a question about who they want to be. Lifestyles provide a framework for our identity and tell a story about who we are and want to be, which is often just as important to maintain as one's health. Other factors can also contribute to undermining a healthy lifestyle. Smoking for example is one way of handling insecurity and anxiety when socialising. The causal connection between lifestyle choices and health are complex. Some lifestyles include both positive opportunities and increased health risks. This applies to lifestyle choices characterised by curiosity, risk-taking, and looking for excitement without any fear of the consequences. The worlds of commerce and adventure sports associate these kinds of behaviour with success, but they also contribute to developing a dependency on alcohol, drugs, and gambling.

Lifestyle as an individual or a collective phenomenon

Lifestyles can, according to Giddens (1999), be understood as a form of social practice that has its routines embodied in our daily habits and behavioural patterns. These practices are constructed and reconstructed through the decisions people make every day, about what they are going to wear, what they are going to eat, and how to behave at work or in their spare time. Individual choices that are affected by peer pressure, self-esteem, role models, risk assessments, and belief in one's own ability to manage one's own life. Our lifestyle choices can, from that perspective, be seen as individual

choices. Our lifestyle choices are, however, also dependent on socio-economic conditions, ethnicity, gender, and sexuality. Life conditions that limit our options and help structure our actions, making the individual lifestyle choice almost perceived as a collective phenomenon. Lifestyles can therefore be described either as independent variables and reasons for our behaviour or as dependent variables caused by societal conditions. In the first case, health is seen as an individual project. It requires the individual to alter their lifestyle and habits if health is to be maintained. In the latter case it is instead societal conditions that stand in the way of health. These conditions could only be affected on a structural level through purchasing boycotts, legislation and regulating the food industry, fast food chains, dairies, and school dinners.

Health care service providers have a lot of contact with vulnerable groups of people who run a greater risk of developing diseases due to their lifestyles. For inactive individuals to break away from a passive sedentary existence, doctors and health care specialists can prescribe a “change of lifestyle” or recommend suitable activities. Similarly, advisory and supportive dialogue, combined with health checks with “bio-feedback” including blood pressure readings and liver values that are followed up over time, have proven to provide good results for alcohol prevention. Preventative health care, aimed at individuals in risk groups, have a long tradition within health care and have therefore been documented more thoroughly by researchers than other approaches aimed at groups, neighbourhoods, or places of work.

Approaches that encourage certain behaviour that are risky and a threat to health might appear to be problematic. They help give the preventative and health promoting work a tangible normative character that sometimes might seem shocking. It often also disregards the individual’s motive for their behaviour or personal judgement of risk. The work is characterised more by authoritative statements rather than by dialogue and discussion.

Diseases related to lifestyle

The ambition of a state of welfare is to create a society with extensive public systems for guaranteeing the entire population’s social, health-related, and economical security. Public health is promoted by economic growth and equal distribution of resources in a society. During the latest decennium, the differences in income have increased in Sweden (Galor, 2009). The modern western society has contributed to increasing health in the population, but has also contributed to chronic lifestyle-related

diseases caused by our way of living. The diseases are the consequences of individual’s habits regarding food, physical activity, smoking, alcohol, and sex. The habits are perceived as an expression for the individual lifestyle and personal taste. Lifestyles are not formed in a vacuum but rather in a societal connection and are not only influenced by personal preferences but also by structural conditions and life conditions (Helge et al., 2003). American investigations show that overweight and obesity account for about 15% of the lifestyle-related deaths. Only smoking is causing more deaths (Mokdad, Marks, Stroup, & Gerberding, 2000).

Health in people in Sweden today

The development of health in Sweden is positive compared to health conditions internationally. However, generally there are large differences when it concerns distribution of health in Sweden. Average life among men and people with higher education is increasing in Sweden (Public Health Report, 2009). The leading cause of this increase is that less people fall ill in heart and blood vessel diseases and that the mortality has been reduced among those who fall ill in these diseases. Changed lifestyle, decreased blood pressure, and lowered levels of cholesterol in the blood contributes to that fewer persons fall ill. The risk of dying in an acute heart attack is dramatically reduced and is nearly halved since the 1970s and the risk to die with a stroke has been reduced by one-third. Improved treatment methods contribute so that the risk of dying in an acute heart attack and/or stroke has decreased considerably in both men and women. Despite increasing average length of life and decreasing child mortality in the population as general the relative difference in health increase between different social groups, for example, between native Swedes and individuals born abroad.

Self-reported psychic health and well-being have deteriorated for both children and adults in all social groups but especially for youths and persons with working class background. Psychological health is decreasing for both men and women but most for young women. Smoking and alcohol drinking has decreased in youths in the ages of 15–16 years. Among children, being overweight has increased considerably between 1980 and 2000 but the increase now seems to level out (Public Health Report [Folkhälsorapport], 2009).

Today about 15–20% of all children are overweight and 3–5% are obese. Food habits have improved and the consumption of refreshing drinks and sweets have diminished considerably during the last years. Also, overweight in adults seems to have levelled out, but despite this about 50% of all men

and 40% of all women in the age of 16–84 years are overweight or obese. Obesity shortens life with about 6–7 years. Drinking alcohol has increased during the last 20 years and the highest alcohol intake has men between 20–24 years. Alcohol related mortality has increased among women in the ages 65–74 years but is decreasing among men in the age group of 25–64 years (Public Health Report [Folkhälsorapport], 2009).

Oral health is considerably worse in all age groups among socio-economic weak groups than in other people. About every 10th person between 16–84 years report that they have bad or very bad teeth. The same amount of persons have not visited a dentist despite that they have a need to do so. About 68% states that the reason for this absence of oral care is their lack of money (Public Health Report [Folkhälsorapport], 2009). Oral health in children is good and is still improving—a majority of all children has no caries and has never had any holes in their teeth.

Limiting ill-health—health promotion

Limiting ill-health through preventative measures is traditionally one of healthcare's main tasks. This is achieved by identifying groups and individuals with unhealthy lifestyles and intervening before they are affected by disease or ill-health. Primary prevention includes health education, health information, and distributing evidence-based knowledge. This also includes legislation and regulation, inspection and issuance of normative recommendations concerning dietary habits, exercise, smoking, and alcohol. If people are already suffering from ill-health or disease, it is important to alleviate and limit the continued spread of the disease.

The preventative work is often pathogenic in nature and aims at drawing attention to the health risks, ill-health, and disease. The objective is to limit or eliminate them altogether. Efforts can be general and aimed at young people, for example, to prevent them drinking alcohol (primary prevention). Efforts can also be aimed at specific risk groups in order to persuade them to stop smoking or drinking alcohol (secondary prevention). Care and treatment of young people with alcohol problems at an early stage usually in health care is described as tertiary prevention.

Primary prevention can include campaigns in the mass media that spread knowledge, affect attitudes, argue for behavioural change, and then cement these in intervention programs. Campaigns that combine various strategies with information, countermeasures

to affect access, and individual support have proven to provide the best results (Poikolainen et al. 2008). In terms of limiting smoking, World Health Organization (2003) found that taxing tobacco products and banning tobacco advertising was the most cost-effective. Smoking bans on government premises, in restaurants, and cafes are isolated measures that, because they affect access, also limit smoking in other contexts. They meanwhile help create tolerable conditions for people visiting or working in these environments. For inveterate smokers, tertiary prevention in the form of antidotal smoking treatments is often the answer.

Other campaigns evaluated by researchers have aimed at limiting the spread of HIV/AIDS and other sexually transmitted diseases. These efforts have been combined with on-call telephone lines, advice, and similar efforts. The specific efforts carried out for risk groups such as homosexual men, Africans, prostitutes, and prison inmates seems to be ethically doubtful because it risks helping to pigeonhole these groups. They have also been criticised for helping other groups like young people repressing the risk they face when having unprotected sex for example (UNAIDS, 2004).

Health trend in today's society

Changes to values in society in terms of people's well-being, health, lifestyle, and quality of life and discussions about health currently deal with "feeling really good" rather than "not feeling bad." The individual health project, thinking about oneself and one's own well-being, emphasises the importance of looking after your body and exercising, having stimulating work, and spending time with close friends. People take responsibility for their own health and lifestyle and actively look for information about what helps improve health and well-being.

But the individual health trend has also contributed to establishing a huge market for products and services that presume to promote health and well-being. These are mainly aimed at young, well-educated health consumers. The market offers all kinds of dietary supplements, health products, training equipment, fitness centre membership, dietary advice, massage, yoga, Spa treatment, plastic surgery, health coaching, personal trainers, products and services marketed by televised media, and a growing number of health magazines. Besides that, this on-going hunt for a healthy and a fit body in itself could be stressful and there is a risk that this trend is shifting the focus from the desire to remain in good health to

an increased fixation with body and appearance and a negative approach to normal ageing.

The individual health trend permeating society today might also increase the inequality in health as many people, for different reasons, are not taking part in it. Today's values that emphasise the individuals' responsibility for their health and lifestyle are basically positive, but it might also contribute to the inequality in people's health and affect tomorrow's health care in an unwanted direction. With an even harder climate in society, there might be a risk that individual health projects undermine the solidarity and the will to accept costs for medical treatment and care for people who risk their health through an unhealthy and risk-taking lifestyle. We could end up with a situation where people no longer are prepared to accept and pay health care costs for people, who they consider to "cause" their own ill-health and sickness by living unhealthy or risky lifestyles.

The individualisation of health in modern society must, at all levels, be balanced with a holistic and global perspective on health, well-being, and quality of life. The lessons learned from threats in the form of pandemics and HIV/AIDS show that public health no longer could be seen as an isolated issue, and that health promotion presupposes a society that stands up and care for everyone. Health promotion demands knowledge, commitment, and long-term efforts for health care workers and, of course, it must always be adjusted to its context.

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